

STATE OF IDAHO  
DEPARTMENT OF INSURANCE  
700 WEST STATE STREET, 3rd FLOOR  
PO BOX 83720  
BOISE, ID 83720-0043

FOR DEPARTMENT USE ONLY

0560  
1315-10  
TOTAL

## STATEMENT OF MONTHLY PREMIUM TAXES PURCHASING GROUPS

PURCHASING GROUP OFFICIAL NAME	
MAILING ADDRESS	DOMICILE STATE

### CALCULATION OF PREMIUM TAX

This tax statement must be completed within thirty (30) days of procurement of insurance. **Delinquent filing and payment of taxes subject insured to a penalty of 6% per annum, compounded annually.** Idaho Code § 41-4816, 41-1233 and 41-4810.

INSURER'S  
NAME \_\_\_\_\_

INSURER'S  
ADDRESS \_\_\_\_\_

TYPE OF  
POLICY \_\_\_\_\_

NAME & LOCATION  
OF RISK INSURED \_\_\_\_\_

EFFECTIVE DATES  
OF POLICY \_\_\_\_\_



### ATTACH DOCUMENTATION WHICH VERIFIES THE AUTHENTICITY OF THE INFORMATION

1. PREMIUM WRITTEN ON POLICY \$ \_\_\_\_\_
2. MULTIPLY LINE 1 BY THE IDAHO TAX RATE OF 2.5% \_\_\_\_\_
3. PLUS PENALTY, IF DUE \_\_\_\_\_
4. TOTAL AMOUNT DUE \$ \_\_\_\_\_  
Make your check payable to: **Idaho Department of Insurance.**  
There will be a \$20.00 charge on all returned checks. Idaho Code § 28-22-105  
Your canceled check is your receipt.

Under penalty of perjury, I declare that this statement has been examined by me and to the best of my knowledge is a true, correct, and complete statement.

\_\_\_\_\_  
Contact Person  
( )  
\_\_\_\_\_  
Telephone Number Ext.

\_\_\_\_\_  
Signature Date  
\_\_\_\_\_  
Name and Title (Type or Print)